STD Medical Record Audit Tool

AUDIT DATE: _____ **County: _____**
MONITOR: _____

Instructions:

- Obtain a copy of the billing sheet for the most recent STD visits within the past 4 weeks.
- If information should be present and is not, place "0" in the box
- If information is present place a "√" in the box
- If the information is not applicable place "NA" in the box

Chart Number	I	II	III	IV	V	VI	VII	VIII	IX	X
Primary Provider ID										
1. Select Medical Record Documentation										
a. Payer Source										
b. Declination of service is signed if applicable per agency policy										
c. Entries are legible										
d. Entries are dated										
e. Telephone calls, letters, home visits, etc. are documented to reflect agency policy regarding client follow-up for additional therapy, test of cure, etc.										
f. Allergies and adverse drug reactions are prominently noted										
2. Entries are signed with name and title of staff making entry:										
a. Interviewer, if not the clinician										
b. Interpreter										
c. STD ERRN										
d. Medical Provider										
e. Treatment nurse, if not the clinician										
f. Disease Intervention Specialist										
g. Others										
3. History and Risk Assessment										
a. STD History documented										
b. Obtains essential history of reason for visit										
c. Chief Complaint is documented										
d. **Recent** antibiotics and **present** medications are documented by name and duration of use										

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3. Continued - History & Risk Assessment	I	II	III	IV	V	VI	VII	VIII	IX	X
e. Vaccine history is documented if known										
f. HIV status and HIV testing history is documented if known										
g. Sexual Risk Assessment is complete										
h. "For Women" section is complete										
i. Details of symptom parameters and sexual risk assessment are described when required for complete understanding										
4. Physical Examination and Laboratory Specimen Collection										
a. Upper body										
b. Lower body										
c. Did the client receive testing appropriate to symptoms and clinical findings?										
d. Ordered lab procedures are checked and stat lab results are documented										
5. Assessment and Treatment										
a. Clinical impression(s) are documented										
b. Did the client receive treatment appropriate to symptoms, clinical findings, and testing?										
c. Therapy corresponds with the clinical impression										
d. Prescriptions and refills are noted										
6. Prevention										
a. Control measures are documented										
b. Instructions and counseling correspond with clinical impression(s) and therapy										
c. Instructions include follow up plan if applicable										
d. Partner notification plan is documented										
7. Evidence of Service Integration										
a. Family Planning/Women's Health										
b. Immunizations										
c. Disease Intervention Specialist										
d. Other										
8. Billing and Coding										
a. ERRN Time is documented in minutes and units										
b. If appropriate was the correct LU code used										
c. If billing private insurance is an E/M code marked										
d. Billing Sheet reflects correct coding with ICD-10										
e. Billing Sheet reflect correct CPT codes										

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MONITOR'S COMMENTS: Please list chart number before each comment.

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